[U.S. Farm security administration]

The Medical Care Program for Farm Security Administration Borrowers

Nearly 70,000 low-income farm families, or about 300,000 persons — borrowers from the Farm Security Administration — are banded into small groups to obtain medical care at a cost which they can afford. This medical program was an outgrowth of the desperate economic situation in which one-fourth of the farm population found itself during the depression.

Five years ago, nearly two million farm families were unable to support themselves without some kind of public aid. Flood and drought had played havoc with crops; credit had vanished; crops were selling at ruinous prices. It was a period of foreclosures and "penny" auctions. Farm families migrated from one area to another seeking work. For these stricken farmers, relief was the only means of support, until the Farm Security Administration began making small loans to enable farmers to make their own living from the land.

These rehabilitation loans, repayable within five years at five percent interest, pay for the seed, livestock, and tools necessary for farming operations. Often the loans also help the family to buy clothing and food until the next harvest.

To borrow from the Farm Security Administration, a farmer must be unable to get satisfactory credit from any other source, public or private; he must be physically able to run a farm, have farming experience, and must be located on a farm. Finally, he must be approved for the loan by a local county committee, which can vouch for his character and ability.

Every loan is based on guidance of the farm family during the period of rehabilitation, to make sure that the money is put to the best possible use. Farm Security Administration supervisors work with the farmer and his family until the loan is repaid, helping him to plan his farming operations and advising him on the most effective methods of raising crops, conserving the soil, and caring for livestock.

Most rehabilitation borrowers are rapidly repaying their loans and becoming self-supporting. It was soon apparent, however, that other families with equal opportunities were making slow progress. A careful investigation disclosed that more than half of the families which failed to make ends meet were handicapped by poor health. Knowing that they could not pay the bills, many of these people had hesitated to consult a doctor. They had let minor ailments go until they became grave. Then the family's livestock or farm tools often had to be sold at a sacrifice to pay for a serious operation or prolonged hospital treatment. Other farmers limped along for years with malaria, pellegra, hookworm, hernias, abscessed teeth or other chronic diseases, which cut down their working ability.

Consequently, the Farm Security Administration started a medical care program for its borrowers, on the theory that a family in good health was a better credit risk than a family in bad health. So far as the government was concerned, this program was simply a matter of good business -- if the family's health handicaps were cleared up, it could get back on its feet and become self-supporting; if they were not, the family might remain dependent on relief for years.

The entire program has been worked out in close co-operation with the State Medical Associations and local medical societies. Before a medical care plan is set up in any state, a memorandum of understanding is drawn up by FSA representatives and the State Medical Association. County agreements, based on this understanding, then are reached with local medical societies.

Although county medical plans vary in detail, according to local conditions and preferences, they follow a general pattern. They all provide for the use of existing local facilities, and fees are based upon the ability of the families to pay -- a principle long recognized by the American Medical Association. Every plan is founded upon three basic principles: (1) Each family has a free choice of its physician from among the participating doctors; (2) Fees are paid by every participating family at the beginning of the operating period, and are held by a bonded trustee; (3) Fees are based upon the ability-to-pay of the families, as indicated by their farm management plans and records.

Under a typical medical care plan, all of the FSA borrowers in the county who wish to participate pay a fixed sum each year for medical care. For the first year, this sum usually is included in the rehabilitation loan. These payments are pooled, in the hands of the county trustee, to serve as a kind of voluntary health insurance system. If a member of the family becomes ill, he may go for treatment to any doctor in the county who is taking part in the plan. All of the doctors submit their bills at the end of each month to the trustee for payment.

Benefits covered in the plan usually include: (a) ordinary medical care, including examination, diagnosis, and treatment in the home or in the office of the physician; (b) obstetrical care; (c) ordinary drugs; (d) emergency surgery; (e) emergency hospitalization.

Some counties have added dental services either as a part of the regular medical care program or under a separate plan. In Arkansas, 40 counties have separate dental plans under which a family obtains emergency dental treatment, simple fillings, extractions, prophylaxis and cleaning at a cost of $4.00 a year for the man and wife and $.50 for each child.

The amount paid for medical care varies according to extent of benefits, size of average farm incomes in the locality, and size of family. A typical payment schedule for medical care in a low-income county is $18 annually for man and wife plus $1.00 for each child, the maximum payment being $26 per family.

All medical care funds are pooled; a proper amount is allocated for hospitalization and emergency needs, including surgical care; and the balance is divided into equal monthly installments.

Physicians' bills are paid from the amount on hand for a particular month, after the bills have been received by the trustee and reviewed by a committee of the local medical society. If possible, all bills are paid in full. If the total bills for a given month exceed the amount available, all bills are proportionately reduced and each physician is paid his pro rata share. If there is some money left over for a particular month, it is carried forward to the next month or to the end of the period, and used to complete payment of old bills.

County or district plans for medical care are now operating in the following:

State	No. of counties participating	No. of families participating
Alabama	33	10,500
Arkansas	69	11,780
Colorado	4	270
Florida	5	650
Georgia	107	13,850
Indiana	5	175
Iowa	3	340
Kansas	35	3,385
Kentucky	2	80
Louisiana	8	1,430
Mississippi	38	6,190
Missouri	12	840
Montana	2	125
Nebraska	20	3,080
New Hampshire	2	45
New Jersey	1	85
New Mexico	13	1,410
North Carolina	17	1,015
Ohio	11	885
Oklahoma	22	2,575
South Carolina	16	3,285
Tennessee	10	415
Texas	37	3,180
Utah	4	790
Vermont	14	350
Virginia	19	795
West Virginia	1	15
Wyoming	3	265
Total	513	67,805

The financial statement for a typical county group health association demonstrates how the program works.

Statement of Physicians' Services, Charges and Payments
for a
TYPICAL COUNTY MEDICAL CARE UNIT
in a southeastern state
(April 1, 1939, through March 31, 1940)

Period	No. of Families	No. Home Visits	No. Office Calls	Charges	Payments	Percent of Payment
Entire Year	262	684	1573	5838.12	3772.48	65
1939						
April	186	31	112	305.50	223.02	73
May	208	43	152	500.00	250.00	50
June	272	71	169	605.50	326.98	54
July	271	32	146	361.00	324.90	90
August	273	68	184	554.50	327.60	59
September	276	46	132	505.50	330.75	65
October	276	55	116	531.00	327.38	62
November	276	48	118	332.37	332.37	100
December	276	87	91	643.00	331.00	51
1940						
January	276	66	109	394.50	330.66	84
February	276	86	117	622.75	334.71	54
March	276	51	127	482.50	333.11	69

Membership fee rate: $12 per year for husband and wife, plus one dollar for each additional person.

Average fee per family: $14.40 per year.
Average size of family: 5.36 persons
Number of home visits per person: .49
Number of office calls per person: 1.12

Medical Care Plans on Homestead Projects

In addition to its rehabilitation loan program, the Farm Security Administration is responsible for 164 homestead projects, of widely varying types, scattered throughout the country. These projects were started by prior agencies, particularly the Resettlement Administration and the Division of Subsistence Homesteads. Most of them have from 100 to 200 low-income families located on adjoining farms. Since nearly all of these communities are some distance from any city, it has often proved hard for the residents to get medical service. Consequently, medical care programs have been organized on 45 projects, and similar arrangements are now being set up on several others. In 19 of these programs, both projects and families of rehabilitation borrowers in the county have combined to use the same medical plan.

A wide variety of arrangements has been made to meet local conditions. Some of the projects have employed a neighboring physician on a part-time basis; or have attracted a resident physician by guaranteeing him a basic income. Whenever possible, the services of all nearby physicians are used.

In several communities, the homesteaders themselves have organized voluntary beneficial associations, which have worked out special agreements with physicians and hospitals. On some projects, the families pay regular cash membership dues, without help from the Farm Security Administration; on other projects the Farm Security Administration lends money to the homesteaders for this purpose, to be repaid when the crops are sold.

Medical Aid to Migrants

Separate from the general program of medical care is the specialized program in California and Arizona. This program gradually is being extended to the Pacific Northwest, Texas, and Florida. These states have experienced an overwhelming migration of needy farm families, which made necessary a completely different type of plan to meet the needs of migratory agricultural workers who required medical attention, but rarely could afford to pay for such aid.

The influx of migrants into California and Arizona since 1935 created a serious public health problem in these two states. Migrant families have a low and uncertain income, live in roadside "jungles," tents, or hastily-improvised shelters. Their "squatter camps" usually have no sanitary facilities.

The constant movement of migrants in search of part-time work from one farming area to another, sometimes more than 300 miles away, contributed to the rapid spread of communicable diseases. Despite the vigilance of the California State Department of Health, outbreaks of smallpox or typhoid in widely separated counties remained a threat.

In May, 1938, the Farm Security Administration, with the cooperation of the California Medical Association, the State Department of Health and the State Relief Administration, formed the Agricultural Workers' Health and Medical Association, incorporated under state laws. Each of the agencies is represented on the Board of Directors of this non-profit association.

Migrants make applications for medical treatment at the Association's district offices or camp treatment centers. A certificate of membership in the health association, which serves as an identification card, is issued to the applicant, who selects his physician from a list of participating doctors. The Agricultural Workers' Health and Medical Association is billed for the medical or hospital services rendered. In many treatment centers, local physicians work in the clinics at designated hours on alternate days. The personnel of the typical treatment centers consists of a part-time physician, a nurse, and a clerk. Services include ordinary medical care, surgery, laboratory, X-ray, dentistry, prescriptions, and diagnostic treatment.

Although the migrant workers are obligated to repay the cost of services "if so requested", their low income makes repayment impossible in most cases. Some workers, however, have been able to repay a few dollars. In view of the health protection provided for the two states under this program, it seems probable that public financial support will continue. Similar conditions prevail in parts of Arizona, Texas, Florida and the Northwest, and similar measures are being undertaken there. There are at present 13 medical care centers in California, 7 in Arizona, 4 in Texas, and 2 in Florida.

Appraisal of the medical care program is difficult. There are bound to be difficulties in a program which affects so many people in widely diverse areas. Most of these troubles have been overcome as they have arisen, however. A strong reviewing committee, drawn from the phisicians' ranks, limits any possible abuses by the doctors. The FSA county supervisor acts in a like capacity for the families, checking up on any unusual demands for service to make sure that no unnecessary burden is imposed on the physicians.

The attitude of both the doctors and families toward the medical care program is, on the whole, favorable. Payments to physicians average, the country over, approximately 60 percent of total bills presented. Many doctors have reported that this is a higher percentage of payment than they receive from their ordinary practice in these areas.

The heart of the program lies in a clear understanding by both physicians and families as to what can be expected under the plan. It is essentially a special program for an under-privileged group of farm people, which could not be adapted for any other part of the population without considerable change. A group of people with higher

incomes would demand a more comprehensive program of medical care, and would be able to pay for such service.

Nevertheless, for the thousands of needy farm people who are gradually re-establishing themselves with FSA help, the plan is a boon.

The fact that most of the medical plans in operation last year are continuing to operate is an indication of their success, since the whole basis of the FSA medical program is voluntary cooperation by both families and physicians.

In its annual meeting at New York City, June 10-14, 1940, the American Medical Association adopted a report by its Reference Committee on Legislation and Public Relations which included the following statement concerning the FSA medical program.

> "The Committee on Legislative Activities has followed the development of the Farm Security Administration plan for medical care of clients. This is obviously an effort to use the insurance principle to pay for medical service. It has been successful in securing cooperation of component county medical societies in many communities and, while acknowledged as experimental in scope, the experience seems to have contributed something to the solution of the medical problems of a farm group which is medically indigent."

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